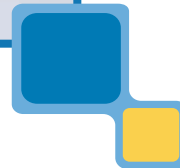


# Medicare Regulatory Compliance and Call Recording

An OAISYS<sup>®</sup> White Paper





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## Medicare Regulatory Reform: Addressing a Costly Problem

Fraud and abuse activities cost the Medicare Program millions of dollars every year. These activities may be carried out by individuals, companies, or groups of individuals. Most doctors, health care providers, suppliers and private companies who work with Medicare are honest. However, there are those intent on abusing or defrauding Medicare, cheating the program out of billions of dollars annually and targeting beneficiaries with high pressure or even illegal sales tactics related to Medicare plan marketing.

The United States spends more than \$2 trillion on health care every year. The National Health Care Anti-Fraud Association estimates conservatively that at least 3 percent—or more than \$60 billion each year—is lost to fraud.<sup>1</sup> President Barack Obama, in an address to Congress, has said rooting out Medicare fraud will be a priority as lawmakers seek to reform the beleaguered health care system.<sup>2</sup> For those honest and ethical Medicare providers equally interested in eliminating fraud and abuse, it becomes especially important that their businesses operate in accordance with established Medicare rules and policies and that they be able to prove conformity if investigated. As regulatory oversight increases, ensuring compliance will become critical to their survival.

In this white paper, we will examine some existing regulations that directly affect the sales and marketing practices of Medicare providers. We will highlight how call recording and voice documentation can help these businesses to achieve regulatory compliance and reduce liability risk. We will also explore general benefits of the technology that can prove valuable for ensuring compliance with potential new regulatory developments providers may face.

## Medicare Improvements for Patients and Providers Act (MIPPA) of 2008

On July 15, 2008, Congress enacted the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA). MIPPA is a complicated piece of legislation, totaling more than 275 pages. The law is perhaps best known for preventing scheduled cuts in Medicare's payments to doctors, but what is less widely recognized is that MIPPA also makes other important and positive changes to Medicare. Some of these changes include a straight set of restrictions and guidelines for sales and marketing tactics that can be employed by Medicare providers.

The Centers for Medicare and Medicaid Services (CMS) originally released these regulations as a means of protecting Medicare beneficiaries from deceptive or high-pressure marketing tactics by private insurance companies and their agents during the Medicare Advantage and Prescription Drug Annual Election Period for the 2009 plan year. The regulations were meant for implementation by both Medicare Advantage (MA) and Medicare Prescription Drug Part D plans by the beginning of their marketing activities starting October 1, 2008. The follow section provides a more detailed explanation of the specific types of Medicare providers affected by MIPPA.

**Medicare Advantage (MA) Plans:** Medicare Advantage Plans are health plan options offered by a private company that contracts with the Medicare program. Beneficiaries who join one of these plans generally obtain all their Medicare-covered health care through that plan. This coverage can include prescription drug coverage. Medicare Advantage Plans include:

- Medicare Health Maintenance Organization (HMOs)
- Preferred Provider Organizations (PPO)
- Private Fee-for-Service Plans
- Medicare Special Needs Plans

**Medicare Prescription Drug Plans:** Medicare Prescription Drug Plans are offered by insurance companies and other private companies approved by Medicare. They add coverage to:

- Original Medicare
- Some Medicare Cost Plans
- Some Medicare Private Fee-for-Service Plans
- Medicare Medical Savings Account Plans

**Medicare Cost Plans:** A Medicare Cost Plan is a type of HMO. These plans may work in much the same way, and have some of the same rules, as Medicare Advantage Plans. In a Medicare Cost Plan, if beneficiaries go to a non-network provider, the services are covered under Original Medicare. They would pay the Medicare Part A and Part B coinsurance and deductibles.

Unfortunately, some unscrupulous Medicare Advantage plans and their brokers and agents have employed unethical and fraudulent practices in their pursuit of new members, from door-to-door sales to forging beneficiaries' signatures. As a result, beneficiaries have lost access to providers or been stuck with large bills. MIPPA codifies consumer protections and gives them the force of law, including prohibiting unsolicited calls and door-to-door sales, restricting where marketing can take place and tightening training and compensation rules for brokers and agents.

Many of these new guidelines impact telephone-based interactions that providers may have with beneficiaries. This includes rules dictating the specific circumstances when phone contact is allowable, the nature of what can be discussed during the course of the conversation and thorough documentation of what was said and agreed to by beneficiaries. A more detailed summary of some of these regulations follows.

### ***Unsolicited Contacts***

This new guidance extends the existing prohibition on door-to-door solicitations to several other activities. These prohibited activities include:

- outbound marketing calls, unless a beneficiary requests a call beforehand;
- calls to former members to market plans or products (note that such calls are permitted for disenrollment surveys, only after the effective disenrollment date and if no sales or marketing information is discussed);
- calls to confirm receipt of mailed materials or acceptance of an appointment made by a 3rd party or independent agent;

- calls/visits after a beneficiary attends a sales event, unless a beneficiary explicitly gives permission;
- unsolicited emails; and
- approaching beneficiaries in common areas (such areas include parking lots, hallways, lobbies, etc.)

Note: there are exceptions to this unsolicited contact rule, including by agents/brokers who enrolled a beneficiary in a plan, and in certain instances in which someone with the Part D Extra Help (Low-Income Subsidy) is being reassigned to a different plan.

### **Cross-selling**

This new guidance prohibits cross-selling of non-health care related products (such as annuities or life insurance) during any MA or Part D sales activity or presentation.

### **Scope of Appointments**

This codifies existing guidance:

- Items to be discussed at a marketing or in-home appointment must be identified prior to the appointment and must be identified on all marketing and advertising materials and announcements; and
- Additional products can only be discussed if the beneficiary requests it and if they are discussed at a separate appointment, at least 48 hours later.

New guidance also requires the plan to document what beneficiaries agreed to hear during their appointments. This should be documented in writing or, ideally, recorded by phone.

## **Durable Medical Equipment Providers**

Durable medical equipment (DME) includes certain medical equipment that is ordered by a doctor for use in the home. Examples include walkers, wheelchairs, hospital beds, standard oxygen delivery systems, braces or crutches. In recent years, CMS has begun an aggressive campaign to curb rampant fraud in the durable medical equipment arena. The Office of Inspector General (OIG) has identified certain types of DME that are particularly vulnerable to billing abuses.

For example, an investigation of a large wheelchair supplier found that the company had submitted false claims to Medicare and Medicaid, including claims for power wheelchairs that beneficiaries did not want, did not need or could not use. In 2007, the company agreed to pay \$4 million and relinquish its right to approximately \$13 million in claims initially denied for payment by CMS.<sup>3</sup>

CMS contracts with the National Supplier Clearinghouse (NSC) to verify that suppliers meet 21 standards before they can bill Medicare. These standards include, among other things, the mandate that the supplier must hold a current license as required by state law, that suppliers not initiate contact with potential beneficiaries by telephone and that suppliers advise beneficiaries of alternative, less expensive methods of obtaining the equipment, including rentals. Additionally, a supplier must maintain a physical facility at an appropriate site, i.e., accessible to beneficiaries, and must keep adequate records of complaints from beneficiaries.



Similar to the aforementioned MIPPA Marketing Guidelines affecting MA and Part D providers, when enrolling in the Medicare program, providers of durable medical equipment, prosthetics, orthotics and supplies (DMEPOS) agree to abide by these 21 DMEPOS standards that are noted in regulations at 42 C.F.R. §424.57 of the Social Security Act. As it specifically relates to phone-based interactions with Medicare beneficiaries, the guidelines are as follows:

### ***Unsolicited Telephone Contacts to Medicare Beneficiaries***

Under Section 1834(a)(17) of the Social Security Act, DMEPOS suppliers are prohibited from making unsolicited telephone contacts, sometimes referred to as “cold calling” to Medicare beneficiaries. There are however, three exceptions where a supplier may contact beneficiaries by telephone. These exceptions are:

1. The beneficiary has given written permission to the supplier to contact them by telephone about furnishing a DMEPOS item;
2. The supplier has furnished a covered DMEPOS item and the supplier is contacting the beneficiary only regarding the furnishing of the item; or
3. If the supplier has furnished a covered item to the beneficiary during the past 15 months of the telephone contact, the supplier may contact the beneficiary about other items that they are able to provide to the beneficiary if needed.

If an unsolicited supplier contact does not fall into one of these exceptions, neither CMS nor the beneficiary is obligated to pay the supplier for items. Furthermore, if the supplier knowingly contacts beneficiaries in violation of Medicare rules on unsolicited contacts to Medicare beneficiaries, and to the extent such behavior establishes a pattern of conduct, CMS may consider excluding the supplier from the program.

Section 1834(a)(17) of the Social Security Act expands these prohibitions by applying them to independent marketing agencies working on behalf of DME suppliers. It also requires DME suppliers to verify that information purchased from third parties and marketing activities which are conducted by such parties do not involve prohibited activities.

CMS has indicated that it will actively encourage the monitoring of non-compliance with the marketing prohibitions noted above. CMS will promote the awareness of these prohibitions through calls with the DMEPOS supplier communities, through beneficiary and supplier outreach activities and various other activities being coordinated from the CMS Regional Offices.

CMS has also suggested that the public report potential violations to Medicare or to the Office of Inspector General (OIG) Hotline. CMS Regional Offices (ROs) will proactively do environmental scanning of marketing activities. When RO staff identifies potential marketing violations, they will forward that information to the CMS Program Integrity contact. Once referred to the CMS Program Integrity contact, the information will be reviewed and, where appropriate, will be further developed for possible sanctions either by CMS or the OIG.<sup>4</sup>

## ***DME Competitive Bidding***

A competitive bidding program for DME suppliers that was intended as a powerful anti-fraud tool was originally launched July 1, 2008, in an effort to lower DME costs, enhance quality and prevent abuse. By limiting Medicare coverage of certain DME items in certain areas to a select group of accredited suppliers that won bids to offer equipment, CMS had hoped to ensure that all approved suppliers were legitimate.

Under the program, beneficiaries in selected areas who need certain equipment are required to obtain it from suppliers chosen by the government through a bidding process. But, the initiative was halted after two weeks when lawmakers agreed to an 18-month moratorium under MIPPA. CMS announced that the rule was effective as of April 18, 2009, giving the green light for the program to restart in January, 2010. Until that time, CMS has said the rule will have no immediate effect on how Medicare patients obtain durable medical equipment, prosthetics, orthotics and supplies.

In the absence of a competitive bidding program, CMS pays set fees for DME used at patient homes. However, CMS has said the prices it pays are too high. CMS sometimes pays several thousand dollars more than some online vendors charge. Government officials have said that the competitive bidding program could reduce expenditures by \$1 billion annually. In addition, officials have said the program could reduce fraud. President Obama has stated his intent to eliminate wasteful spending within the health care system and administration officials have said that a competitive bidding program has been shown to reduce cost and increase quality.<sup>5</sup>

## **Future Strategies for Combating Medicare Fraud and Abuse**

Given the extraordinarily high cost of Medicare fraud to taxpayers and a pledge from President Obama that his administration, "Will root out the waste, fraud and abuse in our Medicare program that doesn't make our seniors any healthier,"<sup>6</sup> those Medicare providers operating legitimately and making every effort to adhere to these various regulations can almost certainly expect a higher level of government oversight into their operations.

In testimony before the Senate Special Committee on Aging in May of 2009, it was stated that the OIG and law enforcement partners have developed a comprehensive strategy to combat fraud, waste and abuse in Federal health care programs. This strategy is built upon five core principles:<sup>7</sup>

1. Individuals and entities that want to participate as providers and suppliers in federal health care programs must be scrutinized prior to their enrollment.
2. Establish payment methodologies that are reasonable and responsive to changes in the marketplace.
3. Assist health care providers and suppliers in adopting practices that promote compliance, including quality and safety standards
4. Vigilantly monitor the programs for fraud, waste and abuse.
5. Respond swiftly to detected frauds, impose sufficient punishment to deter others and promptly remedy program vulnerabilities.



In May of 2009, Senator Mel Martinez (R-FL) of the of the Special Committee on Aging introduced two efforts targeted at detecting and preventing Medicare and Medicaid waste, fraud and abuse. The Seniors and Taxpayers Obligation Protection or "STOP" Act will work to reduce the estimated loss of more than \$60 billion every year by creating fraud prevention and detection systems. The Medicaid Accountability through Transparency or "MAT" Act will require transparency in billing for services and medical equipment.<sup>8</sup>

## **OAISYS Talkument and Tracer Voice Documentation Solutions**

The award-winning OAISYS product portfolio, which includes Talkument® voice documentation and Tracer call center management software, offers robust, reliable call recording capabilities and quality assurance tools to help businesses ensure compliance with Medicare standards. The Talkument and Tracer solutions are vastly different than other call recording solutions on the market. OAISYS products deliver an easy-to-use interface and voice documentation functionality as standard components through patent-pending OAISYS Portable Voice Document (PVD™) technology.

Users can quickly search for, retrieve and play back calls using a Microsoft Outlook® style search folder system. In addition, users can add text annotations, highlight relevant portions of calls and then share voice documents with other parties who may need to review (such as a call center manager or government auditor) via a secure link.

OAISYS solutions also offer unrivaled security protection, as voice documents never leave the centralized OAISYS recording system on which they are stored. All calls remain with the organization, rather than being stored offsite or having copies of the files themselves emailed without oversight or controls. Secure system administration allows for easy assignment of individual and group permissions, as well as log file visibility showing an audit trail of recording access. Furthermore, OAISYS utilizes the maximum 1024-bit encryption rate to deliver the utmost security protection.

Organizations requiring advanced call center management capabilities—such as live call monitoring, coaching, evaluating and reporting—can deploy OAISYS Tracer software. This functionality can prove extremely beneficial for Medicare-related businesses that operate sales, customer service or product support contact centers, delivering a comprehensive training and accountability tool. Tracer's optional desktop video recording functionality can provide even greater insight into specific transactions handled by agents. Additionally, OAISYS provides an unlimited user license for Talkument, extending the benefits of voice documentation beyond the walls of the contact center to support members of every department within the organization.

OAISYS flexible storage options allow organizations to manage their data archival methods as desired. Calls can remain on the central repository and then be migrated to a backup server, burned to CD or DVD or otherwise archived according to the unique best practices of each organization.

## *Call Recording as a Best Practice*

As noted previously, MIPPA requires companies making in-home appointments with Medicare beneficiaries to record appointment setting calls to document the scope of those appointments. In addition to these regulations that directly affect phone-based interactions, there are many other instances where call recording should be considered a best practice that can benefit providers throughout other facets of their business.

Some examples include:

**Plan Reporting of Terminated Agents/Brokers:** If an agent or broker is terminated, that must be reported to the applicable state(s). If state law requires a reason for the termination, that must be provided. Call recordings could potentially be used to support the termination.

**Model of Care:** Special Needs Plans must provide a model of care that includes appropriate providers/specialists, annual reassessments, a plan for goals and objectives with measurable outcomes and an interdisciplinary care management team. Call recording could potentially be used as one component of the goal and objectives measurements and for compliance assurance.

**Prompt Payment of Clean Claims:** Prescription Drug Plans and Medicare Advantage-Prescription Drug providers must pay electronic claims within 14 days and paper claims within 30 days. It can be safely speculated that failure or perceived failure to comply will result in multiple telephone calls, which companies would be well advised to document and record.

Looking at other regulations presented in this paper, call recording can have a significant benefit in protecting Medicare-associated organizations from claims of violation or prohibited practices.

**Unsolicited Contacts:** It is a high probability that companies conducting business by telephone will receive complaints that they have contacted beneficiaries without their consent, in violation of the "Unsolicited Contacts," prohibition. Any outbound marketing calls, calls to former members or after-event follow-up calls could result in a potential allegation of violation. With an OAISYS recording solution in place, supervisors can quickly locate the disputed call and review it to demonstrate the call was made in accordance with the regulation. They can also locate calls with beneficiaries in which agreement was made to receive calls or to schedule supplemental conversations for additional documentation and verification.

**DMEPOS:** These providers in particular face higher scrutiny from regulators as CMS and NSC strive to stamp out fraud and prohibited marketing and billing activities. Scrupulous providers will be under great pressure to ensure their telephone-based communications comply with regulations. They must agree to abide by the 21 standards in the Social Security Act and maintain records of all complaints. Being able to produce the actual complaint calls, along with annotations referencing prior conversations or correspondence in a beneficiary's file, is the most effective method possible of protecting the company from false allegations and unwarranted audits and investigations.



DMEPOS who contract out their marketing to third party firms must oversee those firms to ensure they do not violate the standards or they remain liable for any violations. Easily searchable and annotatable voice documents of those telephone-based conversations provide the easiest means of tracking outside performance and ensuring compliance.

While the current oversight regulations are strict, proposed legislation, such as the STOP and MAT Acts, as well as laws and regulations still to come, will only tighten regulatory oversight. Given the Obama's Administration's pledge to stamp out waste and fraud, companies and providers that have in place the strongest documentation solutions for their paper, electronic and telephone-based communications, both with beneficiaries and with regulatory authorities, can expect to be in a much stronger position for business success and liability protection than those whose documentation capabilities are found wanting.

## Conclusion

The exorbitant expense of Medicare fraud, abuse and waste discovered by investigators and the heightened government scrutiny that has resulted from that makes it imperative that Medicare providers take appropriate action to protect their business operations and ensure regulatory compliance.

OAISYS call recording and voice documentation solutions offer reliable protection from claims of regulatory malfeasance and enable Medicare providers to confidently market their products and services to beneficiaries.

To learn more about how call recording can help ensure compliance with MIPPA sales and marketing guidelines, please download our data sheet at [http://www.oaisys.com/downloads/oaisys\\_mippa\\_compliance.pdf](http://www.oaisys.com/downloads/oaisys_mippa_compliance.pdf)

For more information on call recording for regulatory compliance, please see the complimentary OAISYS white paper, "Call Recording and Regulatory Compliance," available for download here: [http://www.oaisys.com/downloads/regulatory\\_compliance.pdf](http://www.oaisys.com/downloads/regulatory_compliance.pdf).

For more information on how call recording can aid companies in complying with investigative and electronic discovery requirements, download the complimentary white paper, "Call Recording and Electronic Discovery," here: [http://www.oaisys.com/downloads/electronic\\_discovery.pdf](http://www.oaisys.com/downloads/electronic_discovery.pdf).

To learn more about how call recording can help a business with its general processes, such as training, performance enhancement and tracking employee performance, download the free white paper, "Using Call Logging for Business Optimization," available here: [http://www.oaisys.com/downloads/call\\_logging\\_for\\_business\\_optimization.pdf](http://www.oaisys.com/downloads/call_logging_for_business_optimization.pdf).

To find out more about Tracer, Talkument and OAISYS, please contact us at 888.496.9040 or visit us on the web at [www.oaisys.com](http://www.oaisys.com). To find a reseller near you, go to [www.oaisys.com](http://www.oaisys.com), click "support," then "Reseller Locator."



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